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Commenting on:

House Bill No. 5042: An Act Concerning Health Care Cost Growth

Senate Bill No. 15: An Act Encouraging Primary and Preventive Care

My name is Wyatt Bosworth and I am assistant counsel for CBIA, the Connecticut Business & Industry Association. CBIA is Connecticut's largest business organization, with thousands of member companies, small and large, representing a diverse range of industries from across the state. Ninety-five percent of our member companies are small businesses, with less than 100 employees.

1. **House Bill No. 5042: AAC Health Care Cost Growth - Support**

In 2020, Governor Lamont issued Executive Order #5, tasking OHS to (1) monitor healthcare spending growth across all public and private payers and populations in Connecticut; (2) report those findings to the Governor; (3) develop initial annual benchmarks for calendar years 2021 through 2025; (4) convene a Technical Advisory Board to assist in developing benchmarks; (5) work with DSS, DPH, and CID to use the existing OHS Quality Council to assist in the development of quality benchmarks across all public and private payers starting in calendar year 2022.[1] The executive order based healthcare cost growth benchmarks on "total healthcare expenditures, defined as the per capita sum of all healthcare expenditures ... from public and private sources for a given calendar year." Further, the executive order mandated that such benchmarks account for current primary care spending and set a target of 10% for primary care spending as a percentage of total healthcare expenditures by calendar year 2025.

[1] Executive Order #5, Gov. Ned Lamont (Jan. 22, 2020) https://portal.ct.gov/-/media/Office-of-the-Governor/Executive-Orders/Lamont-Executive-Orders/Executive-Order-No-5.pdf?la=en.

HB 5042 codifies the Governor's executive order into state statute. **CBIA has supported OHS's efforts to begin developing a cost-growth benchmark in compliance with the Executive Order in the past, and we support this effort to make it a permanent program today.** Exposing the true drivers behind healthcare costs will not only pressure carriers and providers to abide by the state-established benchmark, but the data collected will also provide tremendous value for future healthcare legislation that can be narrowly-tailored to address the root of the problem that is rising healthcare costs.

Benchmarking has had some instances of success in other states. For example, in Massachusetts, the first state in the nation to implement a cost-growth benchmark, annual growth in total healthcare expenditures fell below the benchmark of 3.6 percent for the three years between 2013 and 2016 and yielded a five-year annual average of 3.4%.[2] The Commonwealth Fund reported that during those years, employers and consumers paid an estimated $7.2 billion less than they would have if the state's spending growth had matched the national average.[3] However, in recent years, the benchmark has been exceeded and Massachusetts is now contemplating fines and performance improvement plans as a way to incentivize its largest provider, Mass General Brigham, to reign in costs.[4]

Other states have joined Massachusetts's efforts as well:

- **Delaware**: established a total healthcare spending growth benchmark of 3.8% in 2018 through an executive order. The order requires tracking trends in quality and population health outcomes[5]

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[2] *Case Study- How the Massachusetts Health Policy commission Is Fostering a Statewide Commitment to Contain Health Care Spending Growth*, The Commonwealth Fund (March 5, 2020) https://www.commonwealthfund.org/publications/case-study/2020/mar/massachusetts-health-policy-commission-spending-growth ("From 2013 through 2017, annual growth in total health care expenditures in Massachusetts fell below the benchmark of 3.6 percent for three years and exceeded it for two years, yielding a five-year annual average of 3.4 percent (Exhibit 2).").

[3] *Id*. ("In 2018, estimated statewide spending growth equaled a revised benchmark of 3.1 percent. In the commercial sector, slower spending growth meant that employers and consumers paid an estimated $7.2 billion less from 2013 to 2018 than they would have if the state's spending growth had matched the national average (Exhibit 3)").

[4] Katie Lannan, *Mass General Brigham required to rein in costs, Health Policy Commission says*, WBUR (Jan. 15, 2022) https://www.wbur.org/news/2022/01/25/health-policy-commission-mass-general-brigham-health-costs

[5] Executive Order 25, Governor John Carney (Nov. 20, 2018) https://governor.delaware.gov/executive-orders/eo25/

- **Rhode Island**: established a total health care spending growth benchmark of 3.2% that went into effect in 2019.[6] The executive order requires agencies to issue year-end reports assessing annual cost growth in the state's health insurance market among commercial, Medicaid and Medicare coverage and at the individual-payer level. The report also must analyze annual cost growth using clinical risk-adjustment methods for sufficiently sized ACOs.
- **Oregon**: established a total health care spending growth benchmark of 3.4% in 2021, largely based on the Massachusetts model.[7]

In conclusion, at the very least, benchmarking provides critical information that will help policymakers develop cost-containment measures to mitigate out-of-control healthcare spending that drives up insurance premiums for individuals and businesses alike. At the very best, benchmarking will incentivize providers and payers to take concrete steps to reign in spending and lower insurance costs for everyone. CBIA urges passage.

2. Senate Bill No. 15: AA Encouraging Primary and Preventive Care - Support

With employer-sponsored health insurance costs rising year-after-year, CBIA has applauded creative efforts in Connecticut to control health care spending across the board. **Senate Bill 15, An Act Encouraging Primary and Preventive Care**, makes meaningful strides to build off the progress that the Office of Health Strategy (OHS) is making to benchmark cost growth and increase primary care spending. **CBIA supports this bill because it is one of many available tools to bring relief to small business health insurance costs.**

In 2020, Governor Lamont directed OHS to set a target for primary care spending in the state to reach ten percent of total health care expenditures by 2025. CBIA supported this initiative, along with the implementation of a cost-growth benchmark, because research after research shows that increased utilization

[6] Rhode Island Sets Healthcare Cost-Control Target, Mercer (Feb. 22, 2019) https://www.mercer.com/our-thinking/law-and-policy-group/rhode-island-sets-healthcare-cost-control-target.html
[7] Oregon passes bipartisan legislation to slow rising cost of healthcare and increase transparency for consumers, OHA (June 19, 2019) https://www.oregon.gov/oha/ERD/Pages/OregonPassesBipartisanLegislationToSlowRisingCostOfHealthCareAndIncreaseTransparencyForConsumers.aspx

of primary and preventive care services results in lower total health care costs and better health care outcomes.

Wellness programs have become staples of large employer health plans for some time now. According to the Kaiser Family Foundation, 84% of large employers (200 or more workers) offering health benefits offered a workplace wellness program in 2019.[8] An estimated 63 million covered employees, including 59 million at large employers work for firms which offer health benefits and a workplace wellness program.

Despite the large uptake of wellness programs amongst large employers, small employers have not followed. According to a survey conducted by the National Small Business Association, only 22 percent of small employers currently offer a wellness program, despite 93 percent stating that the health of their employees is important to their business bottom line.[9] A RAND report from 2015 also found that about 33 percent of the smallest firms (50 to 100 employees) had wellness programs.[10]

A number of factors contribute to the wide discrepancy between large and small employers regarding wellness program uptake. First, large employers, many of whom are self-funded, have a direct interest in maintaining a healthier workplace because it is the employer who is taking on the risk of the employee pool and paying out claims.[11] Second, large employers have more resources to administer a wellness plan, compared to small employers who frequently cite the difficulty to administer a wellness program as an implementation barrier.

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[8] Karen Pollitz & Matthew Rae, *Trends in Workplace Wellness Programs and Evolving Federal Standards*, KFF (June 9, 2020) https://www.kff.org/private-insurance/issue-brief/trends-in-workplace-wellness-programs-and-evolving-federal-standards/. (Compared to 70% in 2008).

[9] Workplace Wellness Programs in Small Business: Impacting The Bottom Line, NSBA (Sept. 27, 2012) https://www.shrm.org/ResourcesAndTools/hr-topics/benefits/Documents/wellness-survey-v3.pdf.

[10] *See Incentives for Workplace Wellness Programs*, RAND (2015) https://www.rand.org/pubs/research_briefs/RB9842.html ("About 33 percent of the smallest firms (50 to 100 employees) and about 80 percent of the larger ones (more than 1,000 employees) had a wellness program; of those, about 60 percent of the smallest employers and 90 percent of other employers used incentives, mostly monetary, to promote program uptake.").

[11] For example, if an insurance carrier offers small group coverage to 100 employers, and only five employers have a wellness program, the benefits that come with increased preventive and primary care utilization cannot be realized for the five employers with wellness programs.

This may include more robust human resource offerings which allow large employers to have a better grasp of trends in their employees' health and lifestyle.

While this bill is a mandate for employers and it will result in a small cost to implement, CBIA is supportive because of the potential return on investment for struggling small employers. According to a recent RAND report, wellness programs reduced average health care costs by about $30 per member per month with disease management programs responsible for the bulk of those savings.[12]

Wellness programs, if tailored appropriately with optimal employee buy-in, can also positively impact employee behavior and result in a more productive, happier workforce.[13]

CBIA is appreciative of the Governor and this committee's determination to enact policies that will steer more insured lives to preventive and primary care services. Unlike other mandates that CBIA has opposed in the past, the health enhancement programs contemplated in SB 15 have the potential, if tailored appropriately, to give employers another tool to help their employees avoid serious disease, incentivize healthy lifestyles, foster a healthier, less-costly group experience, and reduce employee premiums through monetary incentives. Thank you.

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[12] Karen Pollitz & Matthew Rae, *Workplace Wellness Programs Characteristics and Requirements*, KFF (May 19, 2016) https://www.kff.org/private-insurance/issue-brief/workplace-wellness-programs-characteristics-and-requirements/ ("Analyzing results of programs that did collect data, RAND found that overall, wellness programs reduced average health care costs by about $30 per member per month, but 87% of savings were attributable to disease management programs that focus interventions on individuals with already-diagnosed conditions in order to reduce complications and related health care utilization. Lifestyle management wellness programs (e.g., promoting exercise or healthier nutrition) accounted for 13% of health care savings.).

[13] *Id.* ("RAND also found statistically significant that behavioral changes associated with workplace wellness programs, though changes were small and not clinically significant. For example, wellness-fitness program participants were found to increase the number of days per week during which they exercise at least 20 minutes by 0.15 days, compared to nonparticipants. Participants in wellness-weight control programs were found to lose about 1 pound over the first three years, on average, compared to nonparticipants.").